MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Produced by Myers and Stauffer on behalf of the Washington Health Care Authority

Washington State Medicaid Transformation

Independent Assessment of Semi-annual Report 4

Reporting Period July 1, 2019 – December 31, 2019

Findings Report: April 2020

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1. Overview

The Washington State Health Care Authority (HCA) engaged Myers and Stauffer LC (Myers and Stauffer) to serve as the Independent Assessor for the state's Healthier Washington Medicaid Transformation (Medicaid Transformation), Section 1115 Medicaid waiver. The focus of the Independent Assessor's work is on Initiative 1, Transformation through Accountable Communities of Health (ACHs).

As part of this engagement, and as required by the Special Terms and Conditions (STCs) of the waiver, Myers and Stauffer assesses semi-annual reports submitted by each of the nine ACHs. These reports must demonstrate progress and attainment of project-specific milestones and metrics achieved during the reporting period to receive incentive dollars. This findings report represents Myers and Stauffer's assessment of ACH semi-annual reports for reporting period July 1, 2019 to December 31, 2019.

2. Independent Assessor Review Process

The Independent Assessor (IA) used the following process to assess submitted semi-annual reports (SAR).

- **Minimum Submission Requirements Review.** Upon receipt of each ACH's report, a high-level review was conducted to confirm the ACH submitted responses to all questions. Where missing information was identified, a request was made to the ACH for an updated submission.
- **Detailed Assessment.** Primary reviewers conducted detailed assessments of the ACHs' reports. The IA assessed that each ACH addressed all sections of the report and that responses provided detail to confirm progress is being made. Each response to a question within a report sub-section was assessed as complete or incomplete. In addition, the IA assessed each ACHs' reported Implementation Plan progress updates. Where the primary reviewer found a response to be incomplete or requested an additional review for confirmation, a secondary reviewer conducted additional assessment.
- **Requests for Additional Information.** The IA sent requests for additional information (RFIs) to nine ACHs. The RFIs served as an opportunity for ACHs to offer clarification to responses that were initially found to be incomplete and to address identified gaps.

3. Highlights of the ACHs' Semi-Annual Report 4

All ACHs submitted their SARs by the January 31, 2019 deadline. Upon submission of RFI responses, all SARs included sufficient detail to show progress made during the reporting period of July 1, 2019 to December 31, 2019. The IA recommends HCA approval and full credit awarded to ACHs for achievement. The following summary describes findings and highlights examples of activities and updates noted by ACHs within their SAR 4 narratives, workbooks, or implementation plans.

- **Training and Technical Assistance.** ACHs continue to provide thorough training and technical assistance opportunities to providers through monthly meetings, onsite technical assistance, learning collaboratives, and webinars. Required provider reporting has assisted the ACHs in determining milestone completion and individual provider assistance needed. Monthly meetings ensure progress is being made in areas such as development and use of population health management tools, selecting and reporting metrics, and optimizing electronic health records (EHRs). ACHs are also collecting evaluations at partner provider events and webinars to track the effectiveness of trainings and to request input on topics and trainings for which support is needed. Additionally, ACHs continue to obtain

feedback from partners to better align activities and investments to address provider needs. For example, North Central ACH distributed a survey to collect partner feedback on activities that were most beneficial and areas where support might be needed. This shaped workplans and trainings for 2020.

We continue to recommend that the ACHs continually consider opportunities to pool resources to offer shared trainings which will support consistent, statewide messaging and education particularly for care coordination and social determinant of health strategies.

- **Workforce Challenges.** Availability of recovery support services is a continued workforce challenge for ACHs. One issue is the struggle to find licensed providers who will agree to offer medication assisted therapy (MAT) therapy. Licensed prescribers have cited the complexity of managing MAT patients, along with the lack of time and knowledge on how to best approach managing multiple MAT patients. While this workforce issue is a noted ongoing challenge, ACHs are working to increase capacity through additional funding to incentivize partnerships between behavioral health and other care settings, and to offer trainings to increase awareness of which providers are offering overdose prevention tools.

  ACHs are working to address behavioral health workforce shortages in a variety of ways. For example, Greater Columbia ACH (GCACH) has created the Behavioral Health Internship and Training Fund to increase behavioral workforce capacity in the region. The program goal is to "support organizations willing to precept, supervise, or train professionals seeking careers in behavioral health or having a behavioral health component who need clinical experience in order to complete their educations and certification requirements." GCACH allocated $490,000 from Integrated Managed Care (IMC) Phase 2 funds with awards approved in amounts of $5,000 to $40,000 per year per award.

  Another issue noted is a lack of peer counselors and community health workers (CHWs) for recovery support. To address the need for peer counselors, Cascade Pacific Action Alliance (CPAA) and CHOICE Regional Health Network piloted Certified Peer Counselor (CPC) trainings with a specific focus on peers impacted by opioid use disorder (OUD). These trainings increased the number of certified peer counselors in the region. One ACH noted that as of July 1, 2019, peer support services are included in the Medicaid State Plan as billable services, but reimbursement for CHWs was not included. While this reimbursement change was much needed, including CHWs would provide increased capacity to support recovery for substance use disorder (SUD).

- **Integrated Managed Care (IMC).** ACHs continue to work with HCA, managed care organizations (MCOs), and providers to identify and resolve ongoing challenges with implementation of IMC. Specific issues noted include:

  - Preparing EHRs to support new MCO requirements.
  - MCOs have varying templates to gather information which increases provider confusion and burden.
  - Reimbursement and pre-authorization requirements for Residential Treatment Facilities.
  - Leveraging Washington State's health information exchange (HIE) and clinical data repository for full bi-directional whole-person care due to the complexities of SUD client record protection (42 CFR Part 2).

  ACHs note that funding has allowed partners to strengthen technical infrastructure in a short amount of time; however, legislative changes are still necessary to address specific integration goals. We recommend the ACHs monitor progress on these issues, including pilot projects being implemented to

address 42 CFR Part 2 concerns. We also recommend that HCA determine whether its Medicaid Transformation Priorities workgroup, which addresses complex issues that require collective action and alignment, is working to address and resolve each of these challenges. HCA may also consider whether to include opportunities for direct care providers to share their ongoing issues or trends in this workgoup, or a related committee, if none already exists.

- **Finances.** As noted in Table 1, a wide variance of fund distribution was observed across ACHs. Data presented in this table is provided by HCA from the Financial Executor Portal reports.

Table 1. Funds Earned and Distributed During the Reporting Period

	BHT	CPAA	EH	GCACH	HH	NCACH	NSACH	OCH	SWACH
Total Funds Earned During Reporting Period	$2,573,462	$2,339,510	$2,807,412	$3,275,314	$5,146,923	$1,169,755	$10,007,918	$935,804	$1,637,657
Total Funds Distributed During Reporting Period	$10,304,245	$4,301,426	$11,905,930	$6,006,879	$6,777,996	$1,843,281	$4,469,673	$1,968,867	$4,979,135

- **Partnering provider roster.** As part of the submission of materials and to earn the associated achievement value (AV), ACHs are required to update and submit the list of partnering provider sites that are participating in Medicaid Transformation Project Toolkit activities. Table 2 sums the active partners included in each ACH partnering provider roster.

Table 2. Active Project Partners

Project	BHT	CPAA	EH	GCACH	HH	NCACH	NSACH	OCH	SWACH
2A: Bi-directional Integration of Care	120	51	46	87	113	41	102	58	32
2B: Community-Based Care Coordination	109	38	44	●	●	42	8	●	9
2C: Transitional Care	●	36	●	88	100	47	104	●	●
2D: Diversions Interventions	●	●	●	●	●	47	92	58	●
3A: Addressing Opioid Use	106	58	46	91	106	54	133	58	14
3B: Reproductive and Maternal and Child Health	●	34	●	●	●	●	65	58	●
3C: Access to Oral Health Services	●	●	●	●	●	●	28	58	●
3D: Chronic Disease Prevention and Control	106	50	23	87	94	41	92	58	34

- **Description of training and implementation activities.** Implementation of transformation approaches requires specific training and activities in a culturally competent manner. Onsite technical assistance, learning collaboratives and webinars are commonly provided. Group training topics have included stigma around OUD, MAT, LGBTQ, health equity, and Trauma-Informed Care. ACHs are actively working with tribal leaders in their regions to address tribal health equity concerns, while respecting tribal cultural norms and traditional practices. For example, CPAA had two HCA Tribal Liaisons present on Tribal Sovereignty and Indian Health Care Delivery to increase understanding of tribal governments and sovereignty, health disparities, and historical trauma.

  Additionally, ACHs are providing technical assistance for organization-specific equity needs. GCACH worked with Providence St. Mary Medical Center to implement new culturally competent workflows and tools due to technical assistance from GCACH practice navigators. For example, the hospital noted during milestone reporting a higher rate of readmissions for chronic heart failure. Through focus groups, it was determined the cause was a lack of understanding of discharge instructions. As a result, they created supportive materials in both English and Spanish at an elementary reading level. GCACH practice navigators worked with the hospital to create Zone Magnets that describe next steps to take based on patient symptoms.

- **Project 2A: Bi-directional Integration.** ACHs described the financial resources provided to partners to offset infrastructure costs necessary to support bi-directional integrated care activities. For example, both Better Health Together (BHT) and CPAA noted infrastructure funds to specifically support Tribal partners for investment in HIE, information technology equipment, medical equipment and supplies.

  North Central ACH has provided Stage 2 funding for the Whole Person Care Learning Community in two parts. The first part is fixed funding based on annual number of Medicaid encounters for the time, effort, and resources necessary for organizations to implement their change plans, participate in meetings and symposiums, and conduct Maine Health Access Foundation (MeHAF) and patient centered medical home (PCMH) assessment. The second part is variable funding for participation in voluntary learning activities. Organizations have used both types of funding to modify their physical environments, hire staff, and purchase or upgrade EHRs to support integrated care.

- **Project 2B: Pathways Community HUB Model.** ACHs provided a schedule showing dates of initial implementation for each Pathway as shown on Table 3.

Table 3. Date and Types of Pathways Implemented per ACH

Pathways	BHT	CPAA	EH	NCACH	NSACH	SWACH
Adult education	Mar-17	Nov-18	Mar-18	Oct-18	May-19	Mar-18
Employment	Apr-17	Nov-18	Mar-18	Oct-18	Aug-19	Mar-18
Health insurance	May-17	Nov-18	Mar-18	Oct-18	May-19	Mar-18
Housing	Jun-17	Nov-18	Mar-18	Oct-18	May-19	Mar-18
Medical home	Jul-17	Nov-18	Mar-18	Oct-18	May-19	Mar-18
Medical referral	Aug-17	Nov-18	Mar-18	Oct-18	May-19	Mar-18
Medication assessment	Sep-17	Nov-18	Mar-18	Oct-18	May-19	Mar-18
Medication management	Oct-17	Nov-18	Mar-18	Oct-18	~	Mar-18
Smoking cessation	Nov-17	Nov-18	Mar-18	Oct-18	May-19	Mar-18
Social service referral	Dec-17	Nov-18	Mar-18	Oct-18	May-19	Mar-18
Behavioral referral	Jan-18	Nov-18	Mar-18	Oct-18	Jun-19	Mar-18
Developmental screening	Feb-18	Nov-18	Mar-18	Oct-18	~	Mar-18
Developmental referral	Mar-18	Nov-18	Mar-18	Oct-18	~	Mar-18
Education	Apr-18	Nov-18	Mar-18	Oct-18	May-19	Mar-18
Family planning	May-18	Nov-18	Mar-18	Oct-18	~	Mar-18
Immunization referral	Jun-18	Nov-18	Mar-18	Oct-18	~	Mar-18
Lead screening	Jul-18	Nov-18	Mar-18	Oct-18	~	Mar-18
Pregnancy	Aug-18	Nov-18	Mar-18	Oct-18	Jun-19	Mar-18
Postpartum	Sep-18	Nov-18	Mar-18	Oct-18	Oct-19	Mar-18

Note: ~ denotes that NSACH did not report a planned date for Pathways implementation, only actual.

Interim performance data was also collected from ACHs to show the total number of Pathway referrals to Community Care Agencies (CCAs) as shown in Table 4.

Table 4.Number of Pathway Referrals by Community Care Agencies

	BHT	CPAA	EH	NCACH	NSACH	SWACH
Total Community Care Agencies (CCAs)	2	11	5	3	3	4
Total Referral Counts	68	1287	751	1074	858	3454

Note: Greater Columbia ACH, HealthierHere, and Olympic Community of Health are not participating in Project 2B.

Five ACHs are using the software platform developed by Care Coordination Systems (CCS) to collect and monitor performance data. Elevate Health also formed the Pathways Advisory Workgroup (PAW) to ensure community input into the Pathways Community HUB Model operations. The Workgroup includes key community stakeholders who have received services and perform services. They review performance and clinical outcomes to support process improvement. Examples of related measures include:

- Pathways initiated, types and number
- Pathways closed, complete/incomplete
- Pathways average time to close
- Pathways aging (opened more than 30 days and not yet closed)
- Pathways 2X benchmark (pathways open more than 2 times average length of time to complete)
- Number of referrals
- Frequency of client engagement
- Enrollment rates
- Time from initial assignment to outreach
- Return on Investment (ROI) completion rate
- Initial checklist completion rate

We continue to recommend HCA collect interim performance data from ACHs to capture the reach and impact that the model is generating for care coordination systems throughout the state to establish long-term program viability.

- **Project 3A: Addressing the Opioid Use Disorder.** ACHs also provided information about progress on addressing opioid use. Partner trainings continue to be provided on topics including: MAT, Overdose Prevention, Care Transitions, Patient Registries, and Trauma Informed Approaches. Examples were provided of approaches implemented across the core components: prevention, treatment, overdose prevention, and recover supports.

  - Through the Innovation Fund, HealthierHere is investing $600,000 in initiatives to promote continuity of care for individuals with OUD who have received MAT induction in an emergency department (ED) or jail and are released into the community. HealthierHere is funding two projects that will increase warm hand-offs and reduce barriers for individuals to continue their MAT with community-based, low-barrier MAT providers.
  - SWACH partnered with Providence Medical Group to hold a Community Health Summit: Understanding Opioid Use Disorder and Chronic Pain. They brought together providers and professionals specializing in pain management and opioids to discuss pain-related complex care issues for community education.
  - GCACH practice navigators work with providers on prescribing guidelines, and linkages to behavioral health (BH) and MAT for people with opioid use disorders. Each provider must show

how they've increased their capacity to implement use of MAT. Providers are required to have MAT training, identify MAT referral sources, or be a participant of their local Opioid Resource Network (ORN). ORNs identify patients needing intensive case management services, then link patients with physicians or healthcare providers, MAT providers, and other community-based services.

- **Project 3C: Access to Oral Health Services.** ACHs provided information on mechanisms established for coordinating care with related community-based services and supports, including referral relationships established with dentists and other specialists.

    - North Sound ACH's (NSACH) Oral Health Local Impact Network (LIN) Steering Committee engages payers in discussion of payment approaches to support access to oral health services. Staff at NSACH are connecting to a statewide Local Impact Network Learning Collaborative where the five Oral Health LINs across the state can organize and plan for statewide initiatives.

    - Several partnering agencies with Olympic Community of Health (OCH) provide dental care onsite which allows care coordination to be completed electronically through EHR systems. Local agreements are also made between partnering organizations and clinical providers to serve the specialty dental care needs of clients. For example, North Olympic Healthcare Network partners with First Step Family Support Services to reduce access barriers for clients living in the west end of Clallam County. First Step provides transportation and North Olympic Healthcare Network makes weekend appointments.

- **Project 3D: Chronic Disease Prevention and Control.** ACHs noted activities conducted on the Chronic Care Implementation Plan, including examples of integration of clinical and community-based strategies. ACH highlights include:

    - Better Health Together is supporting the Better Health through Housing project which targets Housing and Urban Development (HUD) defined homeless individuals with co-morbid conditions who have accessed the ED four or more times within a year. Once identified, a hospital social worker or CHW screens individuals using the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) tool to determine program eligibility. The CHW is employed through SNAP, a community action agency, and engages eligible individuals by offering bridge housing, if available, and connecting with a SNAP housing specialist for coordination with housing resources. A SNAP monthly dashboard report includes the number of referrals and the number of people housed and is shared with all partners to track outcomes and ensure communication back to the emergency department. All partners are involved in the Spokane Collaborative which creates a touchpoint and networking opportunity to align the Better Health through Housing project with other ACH activities and partners.

    - GCACH created a milestone for patient self-management supports and requires providers to make community-based resources available to patients through formal referral processes or distributing information to patients about the community resources. Catholic Charities of Yakima provides information to patients on the Northwest Justice Project, Northwest Immigrants' Rights Project, Neighborhood Connections, and Wellness House. Barth Clinic makes formal referrals to Consistent Care, Yakima Neighborhood Health Services, and provides information on Oxford Housing and Alcoholics Anonymous/Narcotics Anonymous.

Pay for Reporting (P4R). Twice per year, ACHs gather detailed partnering provider implementation information at a clinic/site level and report aggregate results to the state. P4R metrics provide detailed information on partnering provider progress.

During this reporting period, questions that pertained to Project 2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation requested summary statistics related to partner completion of the Maine Health Access Foundation (MeHAF) Site Self-Assessment Survey. This survey allows partnering providers an opportunity to evaluate their level of integration over the course of the waiver. For Project 3A: Addressing the Opioid Use Public Health Crisis, P4R metric data, sought to gather information related to use of prescribing guidelines and protocols in place to support patients with opioid use disorders.

The state reviews this aggregate information for trends to confirm participation and continued self-assessment. It was noted that the number of respondents for BHT, GCACH, North Sound ACH and OCH saw an increase in respondents during this reporting period compared to the SAR 3 submission.

4. Quality Improvement Strategy

The quality improvement strategy updates convey ACH insights into the current implementation of transformation approaches, barriers identified by partnering providers, and the resources and technical assistance provided to achieve transformation success. Table 5 includes examples of quality improvement strategy updates.

Table 5. SAR4 Quality Improvement Examples

ACH	Barriers	Insights	Adjustments
Elevate Health			
	The following have been challenges: • Bi-directional integration for multi-organization partnerships. • Bi-directional communication and standardization of care management processes across sectors in the community.	• The Community Health Action Team (CHAT) team has been a useful resource in supporting patients in the respite center transitioning from care back into the community. • The Care Continuum Workgroup discovered that Emergency Medical Services (EMS) would be best understood, tracked and captured if more data points were available to analyze.	• Elevate Health plans to scale the Care Continuum Network to incorporate all community-based care coordination programs in the region. • The Care Continuum Workgroup will track emergency service calls and transport with the goal of referring patients to appropriate services to reduce avoidable 911 calls and EMS transports.
Greater Columbia ACH			
	• 42 CFR Part 2 has been a barrier for behavioral health (BH) providers and primary care physicians (PCPs) needing to share patient information for better integrated care.	• Quarter 2 and 3 milestones indicate all organizations have implemented processes for all four project areas and are working with the MCOs to	• GCACH is exploring a secure texting platform developed by Karuna Health. This platform integrates with electronic medical records (EMRs) and allows users to schedule

ACH	Barriers	Insights	Adjustments
		implement population health management tools.	appointments, organize transportation, and repeat messages to patients automatically (e.g., medication reminders).
HealthierHere			
	• Behavioral Health Agencies (BHAs) need additional support to build capabilities and develop a shared organizational understanding of quality improvement (QI) and its importance and greater support for BHAs engaged in value-based contracting.	• HH learned that when establishing new partnerships, it is best to start small, with clear delegation of responsibilities for a particular program or process. • Assigning staff to centrally manage registries and population health information has improved workflows and freed up clinical staff to focus on patient care.	• HH on-boarded community partners in fall 2019 and updated the quality improvement strategy to reflect QI expectations and support for community partners. • As part of 2020 Pay for Progress contracts, partners will be incentivized to develop a QI project that ties to one of HH's P4P metrics.

5. Value-Based Payment (VBP)

ACHs provided examples of how they supported providers to implement strategies in the move towards value-based care. Examples were required for three unique provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 FTEs or fewer), and 3) behavioral health providers.

- **Low VBP knowledge**: GCACH provided The Health Center, a school-based clinic, as an example of a low VBP knowledge provider. During the monthly QI meeting, it was mentioned that the clinic was not familiar with VBP. A practice navigator provided education on VBP and evaluated the clinic's EHR. The EHR assessment identified that it was not set up to create patient registries or track assessment scores. The patient navigator ensured that the EHR was configured to capture data that demonstrated the value of care being provided. Once registries were in place, the Health Center could identify high-needs patients and provide appropriate level of planned care. Practice Transformation milestones also helped implementation of strategies moving them to VBP success.

- **Small provider**: North Central ACH noted that the Center for Alcohol and Drug Treatment (CFADT) is challenged with a small team of staff who are responsible for multiple projects, in addition to learning how to utilize an EHR to monitor quality metrics as they prepare for VBP. Support from the Population Health Management Learning and Action Network (PH LAN), peers, and an assigned practice facilitator will build their capacity to monitor specific measures each month as they implement QI strategies, and develop the critical skills needed around quality measures.

- **Behavioral health provider**: HealthierHere is supporting providers in the move to value-based care through the VBP Academy, an intensive 10-month curriculum that guides behavioral health

organizations through practice transformation with practice coaching on population health, risk stratification, QI, and Plan, Do, Study, Act (PDSA) cycles. Ryther is an example of a behavioral health provider working with HealthierHere to decrease hospitalization and ED use for children, youth, and young adults who also have asthma. They are also determining how the interventions help reduce costly ED use so they can be compensated for their services.

6. Success Stories:

ACHs provided success stories made possible by DSRIP investments, including implementation barriers removed, and lessons learned that allowed the ACH to make modifications as they moved forward. Highlights include:

- **Better Health Together (BHT):** With funding from its Transformation Plan contract with BHT, Planned Parenthood of Greater Washington & Northern Idaho (PPGWNI) was able to launch a behavioral health program in August. The program focuses on mild to moderate behavioral health, particularly depression, anxiety, and stress. At present, staff treat up to 40 patients per week, and are considering expanding to allow walk-ins. Individuals ages 18 and over are currently served through the program, and PPGWNI is working on a waiver to expand services to patients who are ages 13 to 18. Medicaid, commercial insurance, and private pay based on an affordable self-pay scale are accepted. The national Planned Parenthood organization is watching the program's success as a potential model for other sites nationwide.

  In addition to the behavioral health program, PPGWNI is also expanding primary care (PC) work beyond reproductive health. They have started pre-diabetes screening and education, hired a PC clinician interested in medication management, and are applying for a grant to expand the work.

- **Cascade Pacific Action Alliance (CPAA):** While CPAA noted that all Medicaid Transformation implementation partners are working hard and doing innovative, life-changing transformational work that impacts lives across the region, the Lewis County Sheriff's Department (LCSD) was mentioned as a stand-out success. CPAA recognized LCSD's work to reduce barriers to care and the national attention their opioid treatment medication program has received.

  Using DSRIP investments, LCSD implemented an opioid treatment medication program at the county jail. The jail's Health Services Administrator partnered with Medtriq Treatment Services and the jail's medical contractor, NaphCare, to offer this program. Since March 2019, when individuals enter Lewis County jail, they are screened for OUD and offered access to the program. On average, the jail has between 15 and 20 individuals in the program, with approximately 130 graduates to date.

  A significant barrier to recovery support is the 24 to 48-hour Medicaid reactivation timeframe that poses major risk to all Medicaid beneficiaries transitioning from incarceration. Individuals are at a significantly increased risk of overdose death post-release, and access to MAT substantially reduces this risk.

  CPAA provided both DSRIP funding and technical assistance to partners at the Lewis County Sherriff's Department to minimize the impact of the Medicaid enrollment and suspension process for individuals post-release. CPAA provided training to the jail's Community Resource Specialist to become an on-site Health Care Navigator, allowing for in-house, hands-on case management and the initiation of health care benefits immediately following program participants' release from the jail.

Additional activities to address this gap in care have included advocating for shorter Medicaid reactivation timeframes to the State Criminal Justice Workgroup, seeking training for pharmacists on retroactive billing processes, connecting the jail staff with similar programs, and linking the jail staff with experts and peers.

- **Greater Columbia ACH (GCACH**): Columbia County Health System (CCHS) is a Public Hospital District with a Critical Access Hospital. The primary service areas include Dayton, Waitsburg, Starbuck, and surrounding areas. Through its Community Health Fund, the GCACH provided CCHS with $23,750. Below is a picture of CCHS' DSRIP investment.

  CCHS CEO, Shane McGuire, shared CCHS' story, "When we hired our community health workers, Paul and Mike, to help with some challenges we were having with no call/no show patients, we really didn't fully understand the problem we were asking them to help us fix. What we discovered was that reliable transportation was the single largest hurdle and barrier to care affecting these patients. The solution was to use our 2005 van with 223,126 miles on it to assist in meeting these patients' needs, but this was not going to be sustainable given the age and mileage of the van especially when considering the distances we were driving. In addition to the more local appointments in Walla Walla and our own clinics, our team routinely take patients to specialists' visits in the Tri-Cities, Spokane, and even Seattle.

  Along with the reliability issues we were facing, we were also transporting patients with wounds that were much more comfortable traveling on a gurney rather than in a chair or wheelchair. The money received from the Greater Columbia Accountable Communities of Health, Community Health Fund has made it possible for us to order a new, modern and flexible van that can accommodate vehicle chair, wheel chair and gurney patients. The van is also a midsized vehicle making it easier to maneuver as well as maintain a comfortable environment in the winter and summer months. We expect to make roughly 1,800 transports in the first year, and we anticipate the new van's arrival sometime in August!"

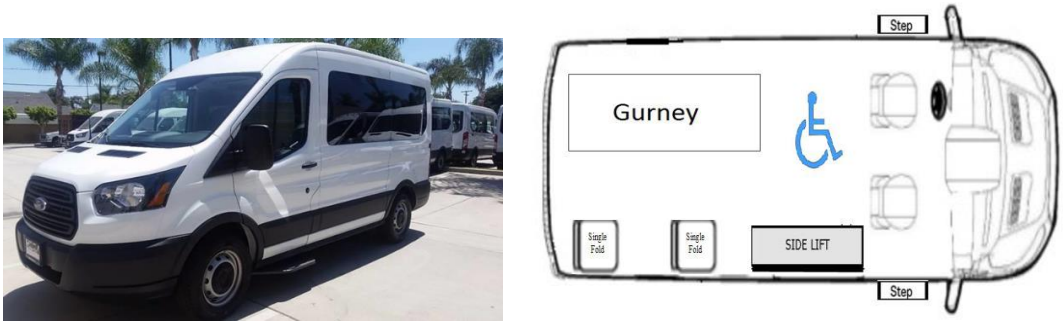

Figure 1; CCHC Transport Van

- **North Sound ACH**: WhidbeyHealth, which operates the WhidbeyHealth Medical Center and clinics in Island County, reported in October 2019 reporting to the North Sound ACH that many of their successes were made possible due to DSRIP investments. They specifically highlighted the "major population health transformational work that has been integrated into the fabric of the community" that was funded by the DSRIP investments. This included the adoption of a community-wide screening and needs assessment which allows them to better target patients and families who are experiencing needs related to depression, suicidality, substance use disorder, domestic violence and abuse, food, housing, utility, electricity, and transportation insecurities. A barrier to implementing such a large task prior to DSRIP funding had been collaboration between community agencies and sites across Island County.

WhidbeyHealth used DSRIP funding to reach out to potential partner agencies to collaborate and learn about best practices that were currently underway.

During this period WhidbeyHealth also launched MyWhidbeyHealth, an improved patient portal that serves all patients of the hospital, clinics, and ancillary services. This new and improved portal was built to address disparities in accessibility, such as lack of internet or phone services, limited transportation access, and other disparities patients may face when accessing their health information and health care team. The EHR systems were also updated to be more inclusive of gender identity and sexual orientation to allow for better data collection. Additionally, WhidbeyHealth trained staff and released a statement about gender inclusivity. Through this work, they hope to better serve the needs of the LGBTQ+ population in the region.

As North Sound ACH moves forward in the Medicaid Transportation Project, the ACH will continue to encourage collaboration and information sharing among partners across the region, much like the extensive work WhidbeyHealth has championed in Island County. In 2020, the ACH will focus further on partner collaboration, identifying where collaborations exist and are thriving and where there are gaps. Through a partner collaboration survey, the North Sound ACH will better understand how partners are connecting and what barriers the ACH can help address through DSRIP investments to ensure regional success.

7. Summary Recommendations for Payment of Incentives

Tables 6 through 8 below provide an overview of ACH projects, Achievement Values (AVs), and incentives that can be earned by ACH for achieving milestones for the reporting period July 1, 2019 to December 31, 2019. Each ACH can earn 1.0 AV per milestone per project. After review of responses to RFIs, the IA found all ACH reports to be fully responsive and complete, and the IA recommends full credit be awarded to each ACH for all milestones as noted in Table 7.

Table 6 provides the total potential AVs for each ACH by project that can be earned. If an ACH is not participating in a project, the table will display a dash (-).

Table 6. Potential Achievement Values by ACH by Project for Semi-annual Reporting Period July 1 – December 31, 2019

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	6	6	-	-	7	-	-	5	24
Cascade Pacific Action Alliance	6	6	5	-	7	5	-	5	34
Greater Columbia ACH	6	-	5	-	7	-	-	5	23
HealthierHere	6	-	5	-	7	-	-	5	23
North Central ACH	6	6	5	5	7	-	-	5	34
North Sound ACH	6	6	5	5	7	5	5	5	44
Olympic Community of Health	6	-	-	5	7	5	5	5	33
Elevate Health	6	6	-	-	7	-	-	5	24
SWACH	6	6	-	-	7	-	-	5	24

Table 7 and Table 8 depicts the number of AVs each ACH has earned by milestone for the reporting period based on the results of the independent assessment.

Table 7. Potential P4R VBP Achievement Values (AVs) by Milestone by ACH, Period July 1, 2019 – December 31, 2019

Milestone	BHT	CPAA	GCACH	HH	NC	NS	OCH	Pierce	SWACH
Identification of providers struggling to implement practice transformation and move toward value-based care	1	1	1	1	1	1	1	1	1
Support providers to implement strategies to move toward value-based care	1	1	1	1	1	1	1	1	1
Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of state-issued Paying for Value Provider Survey	1	1	1	1	1	1	1	1	1
	Full Credit	Full Credit	Full Credit	Full Credit	Full Credit	Full Credit	Full Credit	Full Credit	Full Credit
Total AVs Earned	3	3	3	3	3	3	3	3	3
Total AVs Available	3	3	3	3	3	3	3	3	3

Table 8. Potential Achievement Values (AVs) by Milestone by ACH, Period July 1, 2019 – December 31, 2019

	BHT	CPAA	EH	GCACH	HH	NC	NS	OCH	SWACH
Number of Projects in ACH Portfolio	4	6	4	4	4	6	8	6	4
Milestone: Description of training and implementation activities	4	6	4	4	4	6	8	6	4
Deliverable: Completion of semi-annual report	4	6	4	4	4	6	8	6	4
Deliverable: Completion/maintenance of partnering provider roster	4	6	4	4	4	6	8	6	4
Milestone: Description of each Pathway scheduled for initial implementation and expansion / partnering provider role & responsibilities to support Pathways implementation (Project 2B only)	1	1	1	-	-	1	1	-	1
Milestone: Engagement/Support of IEE Activities	4	6	4	4	4	6	8	6	4
Deliverable: Report on quality improvement plan (QIP)	4	6	4	4	4	6	8	6	4
Address gaps in access & availability of providers offering recovery support services (Project 3A only)	1	1	1	1	1	1	1	1	1
Milestone: Completion of all P4R metrics (Project 2A, 3A only)	2	2	2	2	2	2	2	2	2
Assessed February 2020	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**
Total AVs Earned	24	34	24	23	23	34	44	33	24
Total AVs Available	24	34	24	23	23	34	44	33	24

For each ACH, Table 9 provides incentives available by funding source for completion of Semi-annual Report 4.

Table 9. Total P4R Project Incentives Available by ACH for Achievement of the Implementation Plan Milestone

ACH	Earned AVs	Project Incentives
Better Health Together	24	$4,502,757
Cascade Pacific Action Alliance	34	$4,093,414
Elevate Health	24	$4,912,097
Greater Columbia ACH	23	$5,730,780
HealthierHere	23	$9,005,513
North Central ACH	34	$2,046,707
North Sound ACH	44	$6,140,122
Olympic Community of Health	33	$1,637,366
SWACH	24	$2,865,390
Total		**$40,934,146**

8. Key Considerations by ACH

In addition to the overall trends identified in Section 4 across ACHs, Tables 10 through 27 below provide examples of key considerations, including examples of progress and strengths and examples of adjustments and opportunities for each ACH for HCA review for purposes of ongoing monitoring and that may want to be shared across ACHs. Identified opportunities are based solely on information provided in the semi-annual reports. Upon requests for additional detail or discussion, ACHs may be found to have more extensive work occurring in the identified areas. Recommendations provided by the IA for HCA or the ACH are noted. Each ACH may also assess whether the recommendation should be implemented within their region.

Better Health Together (BHT)

Table 10. Better Health Together (BHT) Key Considerations

Findings for Better Health Together (BHT)	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• BHT has made progress in its support of Tribal Partners, and provided examples of their collaboration: ▪ Tribal Partners are discussing a collaboration to implement a community-based care coordination project. With the Medicaid state plan amendment, they can designate as Tribal FQHCs, bill for services outside of their clinics, and contract with other providers to expand care coordination services. They will create a referral network to allow better service with their tribal health systems. ▪ BHT approved an alternative payment method for Tribal Partners to have flexibility to implement transformation efforts that are culturally appropriate within their health systems. Projects selected include care coordination, mental health peer support specialists in a rural school district, dental health aide therapy implementation, and EHR system implementation. ▪ Through a $50,000 Trauma Informed Approach (TIA) grant from HCA, BHT allocated $8,000 to support training specific to Tribal Partner needs. In September 2019, 35 tribal attendees participated in training facilitated by a national TIA practitioner. • Starting April 1, 2019, BHT is contracting with 19 behavioral health and primary care partnering providers. An additional 22 will enter into contracts in October, 2019. • The BHT Board approved the remaining IMC funds being used to improve access to behavioral health in the region. This will support expanded telepsychiatry services and participation in tele-mentoring programs like Project Echo to increase the supply of behavioral health providers.	• BHT continues to note behavioral health and community-based workforce issues as a top concern and that the shortage of providers may impact regional capacity for service and transformation. ***ACH and HCA Recommendation:*** Domain 1 includes the development and implementation of resources to support workforce strategies at statewide and regional levels. BHT may consider release of additional funds to support workforce incentives. HCA may seek to expand collaboration to support for workforce development and related statewide strategies. • BHT notes continued partnering provider frustration and concerns around data sharing. BHT indicated a need for a statewide vision and solution due to the need for statewide interoperability and the significant investment that will be required to move this work forward. ***HCA Recommendation:*** We recommend HCA confirm for the ACHs if statewide solutions will be pursued through its Medicaid Transformation Priorities workgroup, and if so, how regional solutions should be scaled back or modified. • BHT feels the greatest challenge to transformation is cultural, as many of the practices and policies of health system institutions perpetuate inequities that contribute to avoidable health outcomes as a result of ongoing stigma and systemic racism deeply rooted in the cultures and histories of these institutions and the country. BHT is taking steps to ensure partnering providers engage in critical self-reflection around how the culture and policies either perpetuate or disrupt inequities. ***ACH and HCA Recommendation:*** HCA and ACHs should continually assess state and federal policies to insure equitable distribution of resources and services through a culturally sensitive, person-centered framework.

Table 11. Achievement Values and Earned Incentives for Reporting Period July 1, 2019 – December 31, 2019

Better Health Together			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$2,183,154
2B: Community-based Care Coordination	6	6	$1,500,919
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$272,894
3D: Chronic Disease Prevention and Control	6	6	$545,789
Total	**27**	**27**	**$4,502,756**

Cascade Pacific Action Alliance (CPAA)

Table 12. Cascade Pacific Action Alliance (CPAA) Key Considerations

Findings for Cascade Pacific Action Alliance (CPAA)	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• CPAA was awarded a 3-year grant to create a hub and spoke business model for providing Chronic Disease Self-Management Expansion. • CPAA had two HCA Tribal Liaisons present on Tribal Sovereignty and Indian Health Care Delivery to increase understanding of tribal governments and sovereignty, health disparities, and historical trauma. • CPAA held 14 trainings and events with approximately 641 participants from across the region. • CPAA's Pathways Community HUB, has delivered care coordination services to 426 clients.	• The regional compliance score (showing regional progress towards project implementation) dropped from 79.79% in Q1 (September 2018-Mach 2019) to 68.44% in Q2 (April 2019 – June 2019). ***ACH Recommendation:*** CPAA should continue to monitor regional progress on a quarterly basis. Should regional progress continue to decrease overall in the next quarter, CPAA should be prepared to implement a risk mitigation or similar plan to address the continued overall decrease in project implementation. • CPAA noted in the SAR 4 "CPAA intends to gauge use and understanding of POLST forms in community-based organizations and increase the understanding and use of the form. CPAA will continue to provide TA services to organizations looking to increase the availability and utility of POLST forms" While CPAA has demonstrated an initial plan is in place, it is not clear how CPAA will continue to monitor use of POLST forms long term. ***ACH Recommendation:*** CPAA should define the specific measurement outcomes they intend to meet (for example, 95% of all 2C providers demonstrated use of the POLST form) for this project element if this has not already been determined. • CPAA noted that the Project Director role will not be rehired at this time. The Project Director responsibilities, "Provides oversight of Pathways, Reproductive and Maternal/Child Health and the Youth Marijuana Prevention and Education Program" have been absorbed by the Chief Program Officer who is responsible for providing oversight of all program areas. ***ACH Recommendation:*** CPAA should monitor closely if/how staffing changes (combining the responsible of two jobs into one) are impacting the strategic vision of the ACH or be prepared to revise course if outcomes are unfavorable to meeting stated goals.

Table 13. Achievement Values and Earned Incentives for Reporting Period July 1, 2019 – December 31, 2019

Cascade Pacific Action Alliance (CPAA)			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	7	7	$1,559,396
2B: Community-based Care Coordination	6	6	$1,072,085
2C: Transitional Care	6	6	$633,505
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$194,925
3B: Reproductive and Maternal and Child Health	6	6	$243,656
3D: Chronic Disease Prevention and Control	6	6	$389,849
Total	**38**	**38**	**$4,093,415**

Greater Columbia ACH (GCACH)

Table 14. Greater Columbia ACH (GCACH) Key Considerations

Findings for Greater Columbia ACH (GCACH)	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• GCACH has developed a landing page for Practice Transformation organizations, and the site includes a Reporting Portal where quarterly performance reports are uploaded. The quarterly data is aggregated, summarized, and reviewed by GCACH staff, the GCACH clinical advisory group, and the Practice Transformation Workgroup to understand organizational performance, obstacles and challenges, and make improvement recommendations. The data uploaded helps GCACH recognize struggling providers and helps focus time and attention to those who need it. It also provides GCACH with the topics needed for the Learning Collaboratives. • GCACH entered into an Agreement with Yakama Nation similar to the contracts formed with the six Local Health Improvement Networks (LHINs). The agreement is intended to foster collaboration at the community level and to support work that supports completion of GCACH project areas. • Yakama Nation has agreed in principle with the idea of working together to have GCACH support the tribe in Practice Transformation. The signed agreement would include technical assistance provided by GCACH Patient Navigators, and the tribe would receive financial incentives based upon achievement of milestones. • GCACH has created an internship and training fund to support organizations willing to supervise or train those seeking careers in behavioral health or those who need clinical experience to complete education and certification requirements. The program allocates $490,000 from IMC Phase 2 funds. • GCACH is researching a Community Information Exchange (CIE), NowPow. The nine ACHs are also collaborating on a common strategy in implementing a statewide CIE or, at the least, update electronic community resource directory of social service providers.	• Behavioral health providers have experienced challenges relating to reimbursement for Residential Treatment. GCACH has facilitated meetings to address clarity regarding pre-authorizations, referrals, and scheduling, along with the lack of consistent pre-authorization guidelines. ***ACH and HCA Recommendation****:* In addition to GCACH facilitating meetings and monitoring progress on this issue, we recommend HCA bring issues forward for statewide solutions and advocate for policy changes. • GCACH continues to meet with HCA, the MCOs, and providers to resolve challenges including inconsistent processing and accuracy of MCO claims payments, preparing EHRs to interface with the new behavioral health data requirements, constant changes to the SERI guide, and need for substance use disorder Peer Recovery Support workers. ***ACH and HCA Recommendation:*** In addition to GCACH monitoring progress on this issue, we recommend HCA monitor provider complaints submitted directly to HCA as well as to MCOs to identify any ongoing issues or trends.

Table 15. Achievement Values and Earned Incentives for Reporting Period July 1, 2019 – December 31, 2019

Greater Columbia ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$3,217,279
2C: Transitional Care	6	6	$1,307,020
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$402,160
3D: Chronic Disease Prevention and Control	6	6	$804,320
Total	**27**	**27**	**$5,730,779**

HealthierHere

Table 16. HealthierHere Key Considerations

Findings for HealthierHere	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• In pursuit of QI, partners will be incentivized to develop a QI project as part of their 2020 Pay for Progress contracts that ties to one of HealthierHere's pay-for-performance (P4P) metrics. HealthierHere will review partners' proposed projects prior to launch to ensure all required components, including equity, are included. HealthierHere staff, UW AIMS, and Comagine Health will support partners in both project development and implementation. • Key challenges faced in POLST completion include staff capacity to administer and complete forms and HIE infrastructure to track form completion. To increase the use of POLST forms in Project 2A, HealthierHere is following up with partners identified as having successful practices for increasing POLST availability and will invite them to present their best practices in the 2020 webinar. • Through the Innovation Fund, HealthierHere is investing $600,000 in initiatives to promote continuity of care for individuals with OUD who have received MAT induction in an ED or jail and are released into the community. HealthierHere is funding two projects that will increase warm hand-offs and reduce barriers for individuals to continue their MAT with community-based, low-barrier MAT providers.	• Per HealthierHere, in implementation of bi-directional integration of care, multiple pressures are put on providers from various stakeholders (MCOs, King County ICN, ACHs) that conflict with or require different processes and protocols. As a result, providers may both be confused and risk burnout relative to compliance with disparate protocols. ***ACH and HCA Recommendation:*** HCA and ACH should continue to convene stakeholders to find common ground on what integrated care should look like and what successful implementation looks like. • As a 2019 regional IMC adopter, HealthierHere has come across various issues. Behavioral health agencies lag behind the hospitals, health systems, and FQHCs in IMC readiness. As well, mergers and acquisitions of partners has reduced the partner time and resources to work on the IMC transition and overall delivery system transformation. ***ACH and HCA Recommendation:*** The ACH has recognized multiple challenges in regard to IMC and worked to mitigate these. HCA support and involvement in ACH discussions on payment model alignment with the MCOs and a shared IMC statewide vision would provide further support for the successful implementation of IMC.

Table 17. Achievement Values and Earned Incentives for Reporting Period July 1, 2019 – December 31, 2019

HealthierHere			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$5,055,725
2C: Transitional Care	6	6	$2,053,889
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$631,966
3D: Chronic Disease Prevention and Control	6	6	$1,263,932
Total	**27**	**27**	**$9,005,512**

North Central ACH

Table 18. North Central ACH Key Considerations

Findings for North Central ACH (NCACH)	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• NCACH has distributed 41% of projected incentive expenditures, an increase of 21% from the SAR 3 period. This is a larger increase compared to the SAR 2 period, which was only 6%. • For Project 2B, NCACH included four sample checklists or related documents developed for care coordinators, each of which appear thorough, user friendly, and thoughtfully prepared. • For Project 3A, NCACH notes multiple comprehensive and thoughtful strategies and approaches implemented across each core component. Strategies include, but are not limited to: (1) awards of up to $10,000 for organizations to implement small-scale rapid cycle projects that are shovel ready; (2) utilizing the Distributed Conference Model developed by Washington State University Extension to bring together local leaders across multiple sites; (3) hosting an Evidence-based Dental Pain Care Workshop to train dental providers and staff on new opioid prescribing guidelines and rules; (4) working with partners to develop a comprehensive assessment of school-based prevention activities at each school district in the region; (5) making funding available to partners to train and distribute Narcan to individuals and organizations at risk of witnessing an overdose; and (6) sponsoring a number of individuals with lived experience to attend Recovery Coach Academy and Recovery Coach Train-the-Trainer trainings. • For Project 3A, NCACH has partnered with the Washington Association for Community Health to develop a statewide Chemical Dependency Professional (CDP) Apprenticeship Program that will pair online learning with on-the-job training. This format has the potential to be a game changer for CDP training, especially in rural areas where it is difficult to fill a cohort of students (e.g. Okanogan County) or areas lacking a college with this field of study (e.g. Moses Lake). This approach will increase the number of trained CDPs and increase access to services in more remote locations.	• Approximately 54% of design fund balance remains (slight improvement from what was reported on SAR 3, 60%). NCACH notes that it anticipates expending all Design Funds by the end of the second quarter of 2022. ***HCA Recommendation:*** HCA should continue to monitor distribution of funds to ensure the ACH is adequately supporting administrative/operational functions to support achievement of overall program goals. In addition, HCA should continue to monitor funds distributed to Tribal providers to ensure the ACH is leveraging all opportunities to engage such providers.

Table 19. Achievement Values and Earned Incentives for Reporting Period July 1, 2019 – December 31, 2019

North Central ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$711,898
2B: Community-based Care Coordination	6	6	$489,430
2C: Transitional Care	6	6	$289,209
2D: Diversions Interventions	6	6	$289,209
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$88,987
3D: Chronic Disease Prevention and Control	6	6	$177,975
Total	**39**	**39**	**$2,046,708**

North Sound ACH

Table 20. North Sound ACH Key Considerations

Findings for North Sound ACH	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• In current SAR reporting, 100% of providers reported on-time with only 2.8% of 6,693 milestones reported to be delayed or not-started. • NSACH provides partner support through twice annual partner reporting, data webinars and monthly data learning series, and annual site visits with ACH partners. • Partners requested more opportunities for cross-sector collaboration and a way to learn about which partners are implementing similar transformation approaches. North Sound ACH responded by creating a directory for partners illustrating which partners are committed to and working on strategies and implementation tactics. In addition, North Sound ACH hosted a partner retreat on August 7, 2019 which provided a full-day dedicated to partner collaboration and coalition building. The North Sound ACH will be convening a Local Impact Network to address the opioid crisis. An advisory committee half-day retreat was scheduled for January 14, 2020 to plan the structure of the Local Impact Network. • A specific success for the development of the Opioid LIN is progress toward identifying the LIN's anchor strategies, which have been drafted with input from partners across the North Sound region. The current list of anchor strategies is: Community Education; Access to Care and Treatment; Prevention; Prescriber and Clinic Education; Diversion; Advocacy; and Transitional Care.	• A challenge identified by partners is that of data sharing and working across EHRs and other HIE systems as a barrier to collaboration. To reduce this barrier, the North Sound ACH is continuing to assess appropriate CIE platforms and middleware solutions that could be implemented. To that end, staff and board members attended the Live Well Advance conference in San Diego to learn more about their approach to CIE and data sharing. ***ACH and HCA Recommendation:*** The ACH should consider sharing lessons learned from the conference with ACH peer groups, if they have not already. HCA should consider opportunities to work with the ACH to identify statewide opportunities to leverage knowledge and funds and to address statewide issues. HCA should work with the ACH to determine if ACH specific steps are useful for other ACH's in the state and communicate those if deemed so. • North Sound ACH noted that long term care coordinator retention is a concern regarding sustainability for project 2B, Community-based Care Coordination. However, North Sound ACH elected to implement this project because effective care coordination and sharing of information is key to many of the other project areas, including addressing the opioid crisis and integrating physical and behavioral health. ***ACH and HCA Recommendation:*** HCA should work with the ACH on community based care coordination delivery and payment that allows for sustainability following the waiver.

Table 21. Achievement Values and Earned Incentives for Reporting Period July 1, 2019 – December 31, 2019

North Sound ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$1,964,838
2B: Community-based Care Coordination	6	6	$1,350,827
2C: Transitional Care	6	6	$798,216
2D: Diversions Interventions	6	6	$798,216
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$245,605
3B: Reproductive and Maternal and Child Health	6	6	$307,006
3C: Access to Oral Health Services	6	6	$184,204
3D: Chronic Disease Prevention and Control	6	6	$491,210
Total	**51**	**51**	**$6,140,122**

Olympic Community Health (OCH)

Table 22. Olympic Community Health (OCH) Key Considerations

Findings for Olympic Community Health (OCH)	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• OCH is developing a robust peer learning strategy for 2020, and policies, procedures, and protocols will be widely shared on the OCH website. • OCH worked with an equity organization called Racing 2 Equity to conduct two internal equity trainings, as well as developed a long-term equity plan. • As of January 1, 2020, all four regional mental health providers, and many SUD providers have new EHR systems to support billing and reporting requirements of IMC and value-based arrangements. • OCH is participating in the statewide Collective Medical workgroup that started in December 2019. They connected to MCOs to learn how to expand access to and utilization of PreManage and will start to expand access in 2020 now that OCH is an IMC region. • In September 2019, OCH approved a revised set of intermediary metrics for partner reporting. The metrics were reviewed with partners at the fall site visits and will be reported in February 2020. Reporting on intermediary metrics will allow OCH staff to track progress towards P4P metrics at the individual organization level more frequently, and help prepare providers for value-based contracts.	• Based on progress-to-date reports, OCH identified "limited implementation" in several project areas including ED diversion activities, however OCH is focusing convenings and peer learnings around ED utilization, social determinants of health, and community-clinical linkages during 2020 as a result. ***ACH Recommendation:*** The ACH should evaluate and monitor gaps to implementation and partner understanding to continuously support targeted technical assistance for partners in these identified areas. • In September 2019, the OCH Board of Directors approved a revised set of intermediary metrics for partner reporting to allow OCH staff to track progress towards P4P metrics at the individual organization level and help prepare providers for value-based contracting. ***ACH Recommendation:*** As part of the review cycle, the ACH should ensure that OCH staff compare and discuss results of intermediary metrics with partners so that they may understand potential delays, and/or celebrate progress.

Table 23. Achievement Values and Earned Incentives for Reporting Period July 1, 2019 – December 31, 2019

Olympic Community Health			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	7	7	$806,088
2D: Diversions Interventions	6	6	$327,473
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$100,761
3B: Reproductive and Maternal and Child Health	6	6	$125,951
3C: Access to Oral Health Services	6	6	$75,571
3D: Chronic Disease Prevention and Control	6	6	$201,522
Total	**38**	**38**	**$1,637,366**

Pierce County ACH dba Elevate Health of Washington

Table 24. Pierce County ACH Key Considerations

Findings for Pierce County ACH dba Elevate Health of Washington	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• Elevate Health and the Puyallup Tribe of Nations will host their first annual meeting on January 16th. At this meeting, Elevate Health will learn how to best support the Puyallup Tribe of Nations with the Nurse Family Practice program. The Tribe is dedicated to accomplishing its milestones, commencing with 16 families who are now enrolled in the Nurse Family Practice program. • On November 29, 2019 the Elevate Health Pathways Community received a Level-1 certification from the Pathways Community HUB Institute. Achieving a Level-I certification means Elevate Health has demonstrated that it meets a majority of the national standards for quality community care coordination services and is committed to pursuing excellence and to offering programs and services that are measurable, accountable, and of the highest quality. • Preliminary evaluation of the EMS program has examined several outcome measures by comparing 12-months prior to 12-months post services received. Results have shown a 44% decrease in EMS calls 12-months post services, as well as a 47% decrease in EMS transports. • For Project 2A, all ten participating organizations experienced sustained scores on the MeHAF and many sites saw improvement in at least one or more areas of the MeHAF. Elevate Health provides a table reflecting six factors that support integration. All have implemented at least one factor, while one has implemented all six. All have a psychiatrist available. • In 2019, Elevate Health learned that in-person trainings were preferred to virtual trainings. In addition, they identified that to achieve bi-directional integration they would need to ensure that behavioral health sites also had access to primary care services. In 2020, the focus will be on ensuring there is primary care availability within behavioral health settings.	• Eight positions are marked as adjusted during the reporting period, including CMO, Compliance and Governance Manager, and CCN Operations Manager. In addition to those, there are five vacant positions including two data analyst positions, CCN outreach specialist, IT & Data Services Manager, and a bookkeeper. There has been movement of positions between units and new positions identified based upon review of SAR 3. The two data analyst positions were vacant in SAR 3 as well. ***ACH Recommendation:*** Elevate Health should monitor closely if and how staffing changes and vacancies impact the ACH's strategic vision or be prepared to revise course if outcomes are not favorable to meeting stated goals. • Three of the five CCAs experienced issues in staff turnover. Issues in CHW turnover in 2019 were largely due to equitable pay and limitations in CCA facilitating a pipeline for CHW growth. To address concerns in 2020, an incentive structure will be used to support CHW workforce development and staff retention for each of the CCAs. ***ACH and HCA Recommendation:*** We recommend that the ACH and HCA monitor these workforce development incentives to determine the success or challenges of the approach for replication or modification throughout the state.

Table 25. Achievement Values and Earned Incentives for Reporting Period July 1, 2019 – December 31, 2019

Pierce County ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$2,381,622
2B: Community-based Care Coordination	6	6	$1,637,366
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$297,703
3D: Chronic Disease Prevention and Control	6	6	$595,406
Total	**27**	**27**	**$4,912,097**

SWACH

Table 26. SWACH Key Considerations

Findings for SWACH	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• SWACH has increased use of incentive funding over SAR 3.0, particularly with respect to BH integration efforts. • SWACH partners have reported no significant challenges in hiring staff. Retention of staff has not been a significant barrier to program implementation. In addition, the ACH notes "there are currently no open positions in the Pathways HealthConnect program. Based on feedback and program support from current and potential community partners, SWACH plans for a 2nd wave program expansion in 2020. Approximately 30 additional community-based workers are anticipated to be trained/integrated within Pathways HealthConnect and HealthConnect Hub." • SWACH appears to have been very successful with the HealthConnect Hub implementation. Specifically, recent reporting period outcomes indicate: 239 total people referred, 145 active enrolled clients (60% engagement rate), 1,620 completed “Pathways” (i.e., successful outcomes for engagement with services and care to address identified social, behavioral and physical health risk areas); and HealthConnect Advisory committees established and convening across the SWACH region for input and engagement from community members and stakeholders on maximizing community health opportunities."	• Data sharing is a barrier to the HealthConnect Hub’s capacity to optimize care coordination across programs and initiatives. PRISM scores and access to data supporting the HealthHomes program has not been made available to the ACH Hubs. ***HCA and ACH Recommendation:*** It was noted that this is a concern that remains to be escalated and addressed. The IA recommends that HCA ensure this be addressed during the Medicaid Transformation Priorities workgroup with ACHs and related parties. • Opportunities were noted for additional coordination and actionable follow-up between MCOs and HCA to support Transformation activities. ***HCA and ACH Recommendation:*** Development of an issues tracking log to support issue resolution and escalation to ensure simplified monitoring and action support and communication. A transparent, shared action log or an ACH-specific log for tracking may benefit coordination and issue resolution.

Table 27. Achievement Values and Earned Incentives for Reporting Period July 1, 2019 – December 31, 2019

SWACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$1,389,280
2B: Community-based Care Coordination	6	6	$955,130
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$173,660
3D: Chronic Disease Prevention and Control	6	6	$347,320
Total	**27**	**27**	**$2,865,390**